

## Centers for Medicare &amp; Medicaid Services, HHS

§ 447.54

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 67 FR 41116, June 14, 2002; 75 FR 30261, May 28, 2010]

**§ 447.54 Maximum allowable and nominal charges.**

Except as provided at §§ 447.62 through 447.82 of this part, the following requirements must be met:

(a) *Non-institutional services.* Except as specified in paragraph (b) of this section, for non-institutional services, the plan must provide that the following requirements are met:

(1) For Federal FY 2009, any deductible it imposes does not exceed \$2.30 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 6-month period, the maximum deductible which may be imposed on a family for that period of eligibility is \$13.80. In succeeding years, any deductible may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3)(i) For Federal FY 2009, any copayments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

State payment for the service	Maximum copayment
\$10 or less .....	\$0.60
\$10.01 to \$25 .....	1.15
\$25.01 to \$50 .....	2.30

State payment for the service	Maximum copayment
\$50.01 or more .....	3.40

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(4) For Federal FY 2009, any copayment that the State imposes for services provided by a managed care organization (MCO) may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system. When there is no fee-for-service delivery system, the copayment may not exceed \$3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and § 431.57 of this chapter, for non-emergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of

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the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

#### § 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (c) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

[43 FR 45253, Sept. 29, 1978, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

#### § 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or co-payment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

#### § 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to

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offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

(c) Payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract health services for directly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

[43 FR 45253, Sept. 29, 1978, as amended at 75 FR 30262, May 28, 2010]

#### § 447.58 Payments to prepaid capitation organizations.

If the agency contracts with a prepaid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its recipient members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

[48 FR 5736, Jan. 8, 1983, as amended at 67 FR 41116, June 14, 2002]

#### FEDERAL FINANCIAL PARTICIPATION

#### § 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State's expenditures for services is available for—

(a) Any cost sharing amounts that recipients should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58 (except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

#### § 447.60 Cost-sharing requirements for services furnished by MCOs.

Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through